

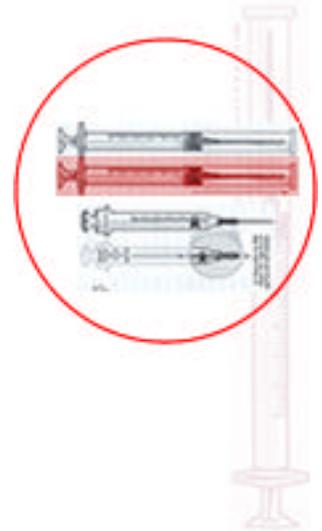
NIOSH recommends that health care facilities use safer medical devices to protect workers from needlestick and other sharps injuries. Since the passage of the Needlestick Safety and Prevention Act in 2000 and the subsequent revision of the OSHA Bloodborne Pathogen Standard, all health care facilities are required to use safer medical devices.



SAFER MEDICAL DEVICE IMPLEMENTATION IN HEALTH CARE FACILITIES

SHARING LESSONS LEARNED

NIOSH has asked a small number of health care facilities to share their experiences on how they implemented safer medical devices in their settings. These facilities have agreed to describe how each step was accomplished, and also to discuss the barriers they encountered and how they were resolved, and most importantly, lessons learned.



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Phase 2: Identify Priorities

For the past seventy-five years, our faith-based health-care facility has played a critical role in contributing to the quality of life of the 600,000 culturally diversified residents in our community. We are dedicated to carrying out our mission of contributing to healthy communities and promoting quality healthcare to all with compassion. This is accomplished through a full spectrum of diagnostic, therapeutic, preventative, and rehabilitation services, which include Neighborhood Affiliate Physician Offices, Parish Nursing Program and a Health Connection Medical Call Center.

1. Types of information used to determine priorities for implementing safer medical devices.

Our facility used data collected by the Employee Health and Central Services departments to assist in determining the priorities for implementing safer medical devices. **We also used information provided by NIOSH and OSHA to assist in the structure and objectives of the committee.**

The Employee Health information was categorized as injury by: device type, clinical area and job category. For example; butterfly collection set, Critical Care department, registered nurse. The committee reviewed this information and used it to determine where the most injuries were occurring and which devices were implicated in the injury. The committee prioritized the search, selection and education/training process for safety devices to reduce injuries from the key areas identified.

Our Phlebotomy Technical Specialist was involved in the investigation of all needlestick injuries. The information regarding how the injury occurred is reported to the committee. This information helped to clarify if the injury was due to an equipment failure or due to improper use of equipment.

Central Services provided the committee with an inventory of safety devices used within the organization. The inventory listed the devices and the clinical areas that used them. This information was important for several reasons. First to determine what safety devices were already utilized within the organization. Second, it identified the clinical areas using safety devices. Lastly, committee members were able to review the available devices and determine if they would meet a need in their respective clinical areas.

Upon review of the available information the committee decided to focus on implementing safer venipuncture devices. This decision was based upon the need to reduce the use of butterfly collection sets within the organization due to cost and safety concerns, and the OSHA standard that venipuncture

collection devices should be single use. The current device did not have an integral safety control and was designed for multiple use.

2. Lessons learned

Data collection was the first problem encountered when developing priorities for intervention. The information provided regarding the type of device involved in the incident was not stratified to the level of the device, rather was categorized as a “phlebotomy” or “non-phlebotomy” related injury. Reviewing the information and stratifying the incidents by device type helped the committee prioritize the highest need for intervention.

We also learned that it is extremely beneficial to have a sitting member of the committee from the patient care administration in our organizational structure. In our organization, patient care staff perform the phlebotomy function therefore, all decisions regarding phlebotomy generate through this administration. The committee had several changes in membership and appeared to move quickly through the decision making process when this administrator was a regular committee member.

By reviewing the supply inventory, committee members learned what devices were available within the organization. Some clinical areas were unaware that certain devices were available, and other areas admitted that although the device was available for a certain use, it was also being used for other functions. This brought home the issue that all supplies should be ordered through a central ordering system. Also, employees should be discouraged from bringing in devices from other organizations for patient use. Employees are encouraged to bring devices to the attention of the appropriate leadership for investigation and trial through the Product Evaluation committee.

One device in particular was being used improperly for blood collection from an intravenous access device. The Phlebotomy Technical Specialist conducted a study of specimen collected with and without this device and was able to report that use of the device did cause increased hemolysis for blood samples. Although this device was deemed as a “safety” and was being used with the best intentions, it caused a specimen integrity issue. The committee was able to use the data collected from the study to impress upon the staff that it should only be used for its intended purpose and the committee was able to find a suitable alternative safety device to replace it, improving safety and preserving specimen integrity.

3. What we would do differently

The product inventory was a critical piece of information to the committee. If we were starting over again, this would be the first piece of information that we would

look at. We would also use this information to select committee members because it would identify what areas had safety devices and what areas were lacking safety devices.

We would also promote that each clinical area perform an individual inventory of sharps and safety devices in use as part of the initial organizational safety assessment.

4. Advice for similar facilities

Inventory all of the products being utilized in the facility early in the process. Compare each area's inventory and assess how they are being purchased to help identify other possible users of available devices. Try to standardize device types across the organization whenever possible to achieve economies of scale purchasing and standard education or training.

Identify members of the committee that are computer literate and enlist their aid to develop spreadsheets and data sheets for reports to the committee.

Enlist the aid of line employees on the committee and in the trials of safety products.

The sharps injury prevention committee should be an active portion of the exposure control plan for the organization.

5. Role of the sharps injury prevention team

The sharps injury prevention team identified areas at risk. The team prioritized areas of greatest need for injury prevention. The team assisted in the search, selection, education and implementation of safety devices.

6. Additional information

The committee was continually challenged by random outcroppings of new discovery from clinical areas that were in need of safety devices but had not been assessed during the initial committee formation. This is why we feel it is important to begin with an inventory of safety items currently in use and then invite any clinical area that uses sharps to be an initial member of the committee.

Another difficulty for our organization was the lack of purchasing control. Areas were able to purchase devices from different vendors for different areas but ultimately the same purpose. Controlling incoming safety devices is one of the best cost/injury savings outcomes of forming this committee.

Materials

Materials distributed at the meeting included a) previous meeting minutes for approval, b) an agenda of items to be discussed - both old and new business, c) copies of Employee Health Service sharps injury statistics (see attached forms), and d) inventory listing of current sharps supplies stocked in Central Service.

Staff Hours

Type of Staff	Hours Spent on Phase 1
Management	38
Administrative	3
Front-line	30
Total	98

Other, non-labor items

Item
1) Tablet for recording minutes
2) Copy Paper

